



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE FORT WORTH

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-14-0006-01

Carrier's Austin Representative

BOX NUMBER: 19

MFDR Date Received

SEPTEMBER 3, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These bills were previously submitted in a timely manner. Please review the attached documentation and pay according to the TDI guidelines."

Amount in Dispute: \$253.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: FLAHIVE OGDEN & LATSON

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2012	Office Visit and Work Status Report	\$126.59	\$0.00
November 26, 2013	Office Visit and Work Status Report	\$126.59	\$111.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.
3. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for Work Status Reports.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- LN – This line was included in the reconsideration of this previously reviewed bill.
- BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
- BL – Additional allowance is not recommended as this claim was paid in accordance with state guidelines, usual/customary policies, or the

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307 for date of service August 21, 2012?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
3. Does the Work Status report meet the requirements of 28 Texas Administrative Code §129.5?
4. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.307(c)(1)(A), this date of service has not met the one year filing deadline. The date the dispute was received in Medical Fee Dispute Resolution was September 3, 2013 and the date of service was August 21, 2012, therefore this date of service is ineligible for review by Medical Fee Dispute Resolution.
2. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided..." Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99213 is:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Expanded Problem Focused History
 - History of Present Illness (HPI) consists of one to three elements of the HPI. Documentation found listed one chronic condition, thus this component was met.
 - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation found one systems: musculoskeletal. This component was met.
 - Past Family, and/or Social History (PFSH) are not applicable.
- Documentation of a Expanded Problem Focused Examination:
 - Requires limited examination of the affected body area or organ system. The documentation found examination of one systems: musculoskeletal. This component was met.

The division concludes that the documentation sufficiently supports the level of service billed; therefore reimbursement is as follows:

- CPT Code 99213: $(34.0376 \div 54.86) \times \$69.31 = \$111.59$

3. In accordance with 28 Texas Administrative code §129.5(d)(2) The doctor shall file the Work Status Report when the employee experiences a change in work status or a substantial change in activity restrictions. Review of the work status report finds that no changes in the work status or activity restrictions were noted from the previous report of August 21, 2013. Therefore reimbursement is not recommended.
4. For the reasons stated above, the service in dispute support the criteria for this level of office visit and reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$111.59.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$111.59 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 23, 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.